EXHIBIT GG

to

PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Civil Action No.: 1:10-cv-00986-JFA

Reimbursement for Emergency Call Care

Aiken Regional MEDICAL CENTERS

www.aikenregional.com

March 12, 2010

Dr. Margo Muniz
410 University Parkway
Suite 2300
Aiken, , SC 29801

Dear Dr. Muniz,

I am writing to inform you that the South Carolina Department of Health and Human Services, pending approval by the Centers of Medicare and Medicaid Services, has determined that Aiken Regional Medical Centers, Inc. qualifies for the SC Medicaid Disproportionate Share Hospital (DSH) Program for the Calendar year 2008.

Attached you will find a list of patients that qualified under the DSH program guidelines and according to our records, were under your care. The services you provided to these qualified patients during the indicated dates of services are eligible for payment of covered services at the SC Medicaid rates by the hospital. Please provide a copy of your FORM CMS -1500 or computer printout that shows detailed billing information for the listed patients. These copies should be sent to Aiken Regional Medical Centers, 302 University Parkway, Aiken, SC 29801, and **attention of Natalie Jarrett**. Submitting the claim forms by April 15, 2010 would help with timely processing for payment.

The payment for these claims will be made in May 2010. If you should require additional information or assistance, please do not hesitate to contact me at (803) 641-5696.

Sincerely,

Mark Tierney

Mark Tierney,
Chief Financial Officer

Called medical
Mark Tierney
7/23/2010
about payment
continued on
fair hearing

Inpatient Private Pay

PT NAME ATN DR NAME	PATIENT #	ADM DATE DSH DATE	DOB SVC	C PT				
MCCAIN ,SALLIE M	105024004	3/21/2008	2/20/1960	E	MUNIZ MARGO	0	3/26/2008 GYN	S
TURNER ,DEBORAH LAKI	105407969	1/31/2008	12/21/1978	E	MUNIZ MARGO	0	2/3/2008 MAT	S
DE LA CRUZ ,GABRIELA	105555825	2/26/2008	8/4/1985	E	MUNIZ MARGO	0	2/28/2008 MAT	S

PT NAME	PATIENT #	ADM DATE	DOB	ATN DR NAME		DSH DATE	SVC
VAZQUEZ ,MARIO	105533087	2/20/2008	6/11/1963	MUNIZ LEOPOLDO	0	5/22/2008	OBS

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN – PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 105 400808

II. MEDICAL RECORD # 464

III. PATIENT NAME Campbell, Melissa

IV. DATES OF SERVICE 1/28 - 2/1/2008

A. PRIMARY PHYSICIAN & SPECIALTY Munis, Margo
Obstetrics/Gynecology

CONSULTING PHYSICIAN:	COMPLETED CONSULT IN MEDICAL RECORD
1. None	
2.	
3.	
4.	
5.	
6.	

June A. Metze, R.N.

DATE February 2010

JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN – PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 10558422

II. MEDICAL RECORD # 60686

III. PATIENT NAME Lewis, Jena L.

IV. DATES OF SERVICE 6/13 – 6/21/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
Obstetrics/Gynecology

CONSULTING PHYSICIAN:	COMPLETED CONSULT IN MEDICAL RECORD
1. None	
2.	
3.	
4.	
5.	
6.	

June A. Metze, R.N.

JUNE A. METZE, R.N.
MEDICAL AUDITOR

DATE February 2010

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN – PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 103680716

II. MEDICAL RECORD # 140399

III. PATIENT NAME McDowell, Jessica

IV. DATES OF SERVICE 12/12/2006

A. PRIMARY PHYSICIAN & SPECIALTY Munoz, Margo
Obstetrics/gynecology

CONSULTING PHYSICIAN:	COMPLETED CONSULT IN MEDICAL RECORD
1. None	
2.	
3.	
4.	
5.	
6.	

June A. Metze, R.N.

DATE February 2010

JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN – PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 1059255275

II. MEDICAL RECORD # 62544

III. PATIENT NAME Usman, Belinda D.

IV. DATES OF SERVICE 5/28 – 6/1/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Marga
Obstetrics/Gynecology

CONSULTING PHYSICIAN:	COMPLETED CONSULT IN MEDICAL RECORD
1. Muniz, Marga (Obstetrics/gynecology) (pt. admitted to Dr Hagan who requested Consult with Marga Muniz, M.D. She saw the pt & then apparently assumed in-pt Care. Discharge Summary written by Dr. Marga Muniz	yes

June A. Metze, R.N

DATE February 2010

JUNE A. METZE, R.N.
MEDICAL AUDITOR

AIKEN REGIONAL MEDICAL CENTER
MEDICAL AUDIT REPORT

PRIMARY PHYSICIAN – PHYSICIAN CONSULTATION AUDIT

INPATIENT UNINSURED ACCOUNTS

I. PATIENT NUMBER 1053447666

II. MEDICAL RECORD # 233598

III. PATIENT NAME Slavin, Jane E.

IV. DATES OF SERVICE 2/11 - 2/14/2008

A. PRIMARY PHYSICIAN & SPECIALTY Muniz, Margo
obstetrics/gynecology

CONSULTING PHYSICIAN:	COMPLETED CONSULT IN MEDICAL RECORD
1. Bayley, John (Family Medicine)	yes
2.	
3.	
4.	
5.	
6.	

June A. Metze, R.N.

DATE February 2010

JUNE A. METZE, R.N.
MEDICAL AUDITOR

Laura,

Here are our bills for the staff call patients in 2008. Our charges were around 13000.00. These will of course be adjusted down like with insurance contracts but this is what we charged for these services.

Jewel had trouble getting Mark Tierney to call her back regarding these past due invoices. When he called Jewel and Maria were in the room and he told them that Margo's payment was contingent on the outcome of her "fair hearing". This was on 7/28/2010.

Thanks,

Marla

Marla

Payment is contingent on whether she is on staff or not from fair hearing
Talked to Mark Tierney on 7/28/2010

MetLife

32587

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER X (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 476554444
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SLAVIN JANE				3. PATIENT'S BIRTH DATE MM DD YY: 12 03 1947	SEX: M / F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial): SLAVIN JANE
5. PATIENT'S ADDRESS (No., Street): 905 GEORGETOWN DRIVE				6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other			7. INSURED'S ADDRESS (No., Street): 905 GEORGETOWN DRIVE
CITY: NORTH AUGUSTA	STATE: SC			8. PATIENT STATUS: Single / Married / Other X			CITY: NORTH AUGUSTA STATE: SC
ZIP CODE: 29841	TELEPHONE (Include Area Code): (803) 278-2361			Employed / Full-Time Student / Part-Time Student			ZIP CODE: 29841 TELEPHONE (Include Area Code): (803)278-2361
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous): YES / NO X			a. INSURED'S DATE OF BIRTH MM DD YY: 12 03 1947 SEX: M / F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M / F				b. AUTO ACCIDENT? YES / NO X PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? YES / NO X			c. INSURANCE PLAN NAME OR PROGRAM NAME: ARMC
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 02 11 2008 TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 183 8 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 11 08	02 11 08	21		58210		1	4788 00	1		NPI	1457348526
2 02 11 08	02 11 08	21		58950	51	1	2196 00	1		NPI	1457348526
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
204598150 EIN X	32587P18742	YES X / NO	$ 6984 00	$	$ 6984 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (803)649-6366
MARGO J HEIN MUNIZ MD	AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801	PMC 410 UNIVERSITY PKWY AIKEN SC 29801

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WITH 16-ENVY WINDOW SS

32582

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 247693547

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEWIS TRENA L

3. PATIENT'S BIRTH DATE MM DD YY: 01 11 1973 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): GARDENHIRE TRENA L

5. PATIENT'S ADDRESS (No., Street): 500 PEPPER BRANCH ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 500 PEPPER BRANCH ROAD

CITY: BEECH ISLAND STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: BEECH ISLAND STATE: SC

ZIP CODE: 29842 TELEPHONE (Include Area Code): (803) 593-8005

ZIP CODE: 29842 TELEPHONE (Include Area Code): (803)593-8005

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 01 11 1973 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ARMC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 13 2008 TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 614 6
2. 617 5
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 13 08	06 13 08	11		58661		12	2040 00	1		NPI	1457348526
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 204598150 [X]

26. PATIENT'S ACCOUNT NO.: 32582P17916

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 2040 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 2040 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MARGO J HEIN MUNIZ MD

32. SERVICE FACILITY LOCATION INFORMATION

PARKSIDE MEDICAL CONSULTANTS
410 UNIVERSITY PKWY
AIKEN SC 29801

33. BILLING PROVIDER INFO & PH. # (803)649-6366

PMC
410 UNIVERSITY PKWY
AIKEN SC 29801

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

SECOND FOLD

FIRST FOLD WHDF-10-BNF PWHDF-10-BNF-03

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PICA	CARRIER
							249232373		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
MCCAIN SALLIE M	02 20 1960 M F X	MCCAIN SALLIE M	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
65 KNIGHT LANE	Self X Spouse Child Other	65 KNIGHT LANE	
CITY	8. PATIENT STATUS	CITY	STATE
TRENTON	Single Married Other X	TRENTON	SC
STATE SC	Employed Full-Time Student Part-Time Student		
ZIP CODE 29847	TELEPHONE (Include Area Code) (803) 663-7749	ZIP CODE 29847	TELEPHONE (Include Area Code) (803) 663-7749
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY / SEX	
		02 20 1960 M F X	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		ARMC	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 620 0 3. 617 0 2. 614 6 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
03 21 08	03 21 08	21		58661		123	1734 00	1		NPI	1457348526
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
204598150 X	32581P19135	X YES NO	$ 1734 00	$	$ 1734 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
ARGO J HEIN MUNIZ MD	AIKEN REGIONAL MEDICAL CENTER	(803) 649-6366
SIGNED 3/19/2010	302 UNIVERSITY PKWY	PMC
	AIKEN SC 29801	410 UNIVERSITY PKWY
		AIKEN SC 29801

SECOND FOLD — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC-10-E00 / WHCF-10-E00-SS

32583

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY
AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
						X	248338462		

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
OSMAN BELINDA D	03 23 1972 M F X	OSMAN BELINDA D

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
283 HERBERT LANE	Self X Spouse Child Other	283 HERBERT LANE

CITY	STATE	8. PATIENT STATUS	CITY	STATE
WILLISTON	SC	Single Married Other X	WILLISTON	SC

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
29853	(803) 266-5135	Employed Full-Time Student Part-Time Student	29853	(803)266-5135

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 03 23 1972 M F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: ARMC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes,* return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED SIGNATURE ON FILE DATE 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. 789 00 2. 625 9 3. 787 91 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 26 08 05 26 08	23		99254		123	242 00	1		NPI	1457348526
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
204598150 X	32583P21161	X YES NO	$ 242 00	$	$ 242 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. #
MARGO J HEIN MUNIZ MD 3/19/2010	AIKEN REGIONAL MEDICAL CENTER 302 UNIVERSITY PKWY AIKEN SC 29801	(803)649-6366 PMC 410 UNIVERSITY PKWY AIKEN SC 29801

0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHDF-10-EHK WHDF-10-EHKSS

32584

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 248338462

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): OSMAN BELINDA D

3. PATIENT'S BIRTH DATE MM DD YY: 03 23 1972 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): OSMAN BELINDA D

5. PATIENT'S ADDRESS (No., Street): 283 HERBERT LANE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 283 HERBERT LANE

CITY: WILLISTON STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: WILLISTON STATE: SC

ZIP CODE: 29853 TELEPHONE (Include Area Code): (803) 266-5135

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 29853 TELEPHONE (Include Area Code): (803)266-5135

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 23 1972 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ARMC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED SIGNATURE ON FILE DATE 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 789 00
2. 569 3
3. 617 0
4. 568 0

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 27 08	05 27 08	21		99233		1234	150 00	1		NPI	1457348526
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 204598150 SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 32584F21161

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 150 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MARGO J HEIN MUNIZ MD

32. SERVICE FACILITY LOCATION INFORMATION

AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PKWY
AIKEN SC 29801

33. BILLING PROVIDER INFO & PH. # (803)649-6366

PMC
410 UNIVERSITY PKWY
AIKEN SC 29801

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SIGNED ORIGINAL — PLEASE DO NOT STAPLE — FIRST FOLD WITH CARE — SECURELY STAPLE ALL PAGES — SECOND FOLD

32585

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY
AIKEN SC 298021117

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 248338462

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): OSMAN BELINDA D

3. PATIENT'S BIRTH DATE: 03 23 1972 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): OSMAN BELINDA D

5. PATIENT'S ADDRESS (No., Street): 283 HERBERT LANE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 283 HERBERT LANE

CITY: WILLISTON STATE: SC

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: WILLISTON STATE: SC

ZIP CODE: 29853 TELEPHONE (Include Area Code): (803) 266-5135

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 29853 TELEPHONE (Include Area Code): (803)266-5135

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 03 23 1972 SEX: M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ARMC

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete Item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 3/19/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 789 00
2. 569 3
3. 617 9
4. 568 0

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 28 08	05 28 08	21		99233		1234	150 00	1		NPI	1457348526
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 204598150 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 32585P21161

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 150 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MARGO J HEIN MUNIZ MD
3/19/2010

32. SERVICE FACILITY LOCATION INFORMATION
AIKEN REGIONAL MEDICAL CENTER
302 UNIVERSITY PKWY
AIKEN SC 29801

33. BILLING PROVIDER INFO & PH. # (803)649-6366
PMC
410 UNIVERSITY PKWY
AIKEN SC 29801

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-1500 / WHCF-1500-SS

32586

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AIKEN REGIONAL MEDICAL C
302 UNIVERSITY PARKWAY

AIKEN SC 298021117

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X OTHER
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	248338462
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	OSMAN BELINDA D
3. PATIENT'S BIRTH DATE MM DD YY / SEX	03 23 1972 M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	OSMAN BELINDA D
5. PATIENT'S ADDRESS (No., Street)	283 HERBERT LANE
6. PATIENT RELATIONSHIP TO INSURED	Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	283 HERBERT LANE
CITY / STATE	WILLISTON / SC
8. PATIENT STATUS	Single [ ] Married [ ] Other [X]
CITY / STATE	WILLISTON / SC
ZIP CODE / TELEPHONE (Include Area Code)	29853 / (803) 266-5135
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	
ZIP CODE / TELEPHONE (Include Area Code)	29853 / (803)266-5135
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	03 23 1972 M [ ] F [X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	M [ ] F [ ]
b. AUTO ACCIDENT? PLACE (State)	YES [ ] NO [X]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	ARMC
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 3/19/2010

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO	
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? $ CHARGES	YES [ ] NO [X]
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)	1. 789 00 / 3. 236 3 / 2. 614 1 / 4. 569 3
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 29 08	05 29 08	21		58661		1234	2040 00	1		NPI	1457348526
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DUE
204598150 [ ] [X]	32586P21161	[X] YES [ ] NO	$ 2040 00	$ / $ 2040 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MARGO J HEIN MUNIZ MD 3/19/2010

32. SERVICE FACILITY LOCATION INFORMATION

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302 UNIVERSITY PKWY
AIKEN SC 29801

33. BILLING PROVIDER INFO & PH. # (803)649-6366

PMC
410 UNIVERSITY PKWY
AIKEN SC 29801

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-EW-J WHCF-10-EW-SS